CHAPTER OVERVIEW

This chapter addresses the case planning process from the legal basis for the plan, through development and implementation, and, finally, evaluation of progress.

10.1 Legal Basis

Public Law 96-272, the Adoption Assistance and Child Welfare Act of l980, states that "in each case, reasonable efforts will be made:

"Reasonable efforts means the exercise of reasonable diligence and care by the Division to utilize all available services related to meeting the needs of the juvenile and the family."

1. Prior to the placement of a child in foster care to prevent or eliminate the need for removal of the child from his home, and

2. To make it possible for the child to return to his home. In order to make "reasonable efforts," a case plan must be developed. The purpose of the case plan is to assure that a child in placement receives proper care; that services are provided to the parents, child and placement provider in order to improve the conditions in the parents' home; to facilitate return of the child to his own home or to another permanent placement, and to address the needs of the child while in foster care, including a discussion of the appropriateness of the services that have been provided to the child under the plan."

Chapter 211.183, RSMo, asserts that in juvenile court proceedings the Children's Division (CD) shall have the burden of demonstrating "reasonable efforts to prevent or eliminate the need for removal of the child and, after removal, to make it possible for the child to return home. If the first contact with the family occurred during an emergency in which the child could not safely remain at home even with reasonable in-home services, the Division shall be deemed to have made reasonable efforts to prevent or eliminate the need for removal."

Chapter 211.181, RSMo, provides that within 30 days of the Division receiving custody of a child, a long-range permanency treatment plan shall be developed. The following components shall be included in the long-range treatment plan:

- The type of placement which will serve the best interest and special needs of a child and provide the least restrictive setting;

- The projected length of care needed by the child and the projected cost for providing such care;

- Services needed by the child and his family to facilitate reunification and the projected cost of such services; and

- Certification from the Division director or designee that the placement and/or services recommended are available.

- Documentation that the parents have or have not been convicted of any of the felony offenses as described below:

  Section 210.117, RSMo states that no child taken into custody of the state shall be reunited with a parent or placed in a home in which the parent or any person residing in the home has been found guilty of, or pled guilty to, a felony violation of chapter 566 RSMo, with the exception of 566.034 RSMo, or section 568.020, 568.045, 568.060 (except for subdivision (1) of subsection (1).), 568.065, 568.070, 568.080, 568.090, or 568.175, RSMo when a child was a victim, or has an offense in another state , that would be considered a felony violation of the above stated chapters, where a child was a victim.

  - Specific offenses:
    - 566.020 - Mistake as to incapacity or age
    - 566.023 - Marriage to victim at time of offense
    - 566.025 - Evidence that defendant has committed other charged and uncharged crimes of a sexual nature involving victims under fourteen
    - 566.030 - Forcible rape and attempted forcible rape
    - 566.040 - Sexual assault
    - 566.060 - Forcible sodomy
    - 566.062 - Statutory sodomy, first degree
    - 566.064 - Statutory sodomy – second degree
    - 566.067 - Child molestation, first degree
    - 566.068 - Child molestation, second degree
    - 566.070 - Deviate sexual assault
    - 566.083 - Sexual misconduct involving a child
    - 566.090 - Sexual misconduct, first degree
    - 566.093 - Sexual misconduct, second degree
    - 566.095 - Sexual misconduct, third degree
    - 566.100 - Sexual abuse
    - 566.111 - Unlawful sex with an animal
    - 566.151 - Enticement of a child
    - 568.020 - Incest
    - 568.045 - Endangering the welfare of a child in the 1st degree
    - 568.060 - Abuse of a child, penalty (minus sub. 1, subs.1)
    - 568.065 - Genital mutilation of a female child

568.070 - Unlawful transactions with a child
568.080 - Child used in sexual performance
568.090 - Promoting sexual performance by a child
568.175 - Trafficking in children

- Exceptions to the above offenses
  566.034 - Statutory rape, second degree
  568.060 - Abuse of a child, Subdivision1, subsection1: Knowingly inflicts cruel and inhuman punishment upon a child less than seventeen years old.

- Nothing in this section shall preclude the division from exercising its discretion regarding the placement of a child in a home in which the parent or any person residing in the home has been found guilty of, or pled guilty or no contest to any offense excepted (listed above) in this section. Therefore, the division may decide to place a child in the home where a parent has been found guilty of one of the above stated offenses, however is not required to do so.

If during the provision of services, staff determine based on self disclosure or through the assessment of the parent that the parent has a known criminal history, involving any of the above stated felony convictions, the worker is to obtain two sets of fingerprints from the parent(s) and submit them to the Highway Patrol for an extensive background check prior to reunifying the child with the parent.

10.2 Definition and Purpose

During the family assessment process the family Children's Service Worker and other members of the Family Support Team (FST) will establish a permanency goal and identify service needs. Once the permanency option is determined, the family treatment plan, Form CS-16 is completed. The family treatment plan replaces the written service agreement.

The family treatment plan is the written working agreement between the family, child, placement provider and the family's Children's Service Worker. The plan is initiated within 72 hours and reviewed by the full FST within 30 days of the child being placed in the custody of the Children's Division.

If, at any time, it appears that termination of parental rights will be recommended, a statement to that effect should be written under "Additional Information" on the Family Plan for Change CS-16b.

10.3 Factors to Consider in Family Reunification

The Family treatment plan has four (4) purposes:

1. It provides overall structure and direction to the casework process through the identification of goals and assignment of time-limited tasks.

2. It documents the willingness of the family to participate in reunification services and the Division and other FST members' willingness to assist by providing services.

3. It provides an instrument to evaluate the progress of the family toward reunification and the accountability of all participants.

4. It documents the Division's "reasonable efforts" to reunify families. A family treatment plan, form CS-16, is required on all cases. If the permanency planning goal is reunification, the family treatment plan shall be developed with the child's parents/caretakers, and, when feasible, the child. If the permanency goal is adoption, the family treatment plan shall be developed with the adoptive resource, when identified, and, if feasible, with the child's parents/caretakers and the child. If the permanency planning goal is guardianship, the family treatment plan shall be developed with the potential guardian, if identified, and, if feasible, the child's parents/caretakers and the child. If the permanency goal is placement with a fit and willing relative, the family treatment plan shall be developed with the child's parents/caretakers, the relative resource, and the child. If the permanency goal is Another Planned Permanent Living Arrangement, the family treatment plan shall be developed with the child's parents/caretakers, the placement resource, and the child. All parties to the agreement or their agent/representative shall sign the family treatment plan. If any party refuses to sign, the Children's Service Worker shall document that party's disagreement and the reason for the disagreement.

   It is essential that the family treatment plan be specific about:

   - What the FST hopes to accomplish during the treatment process;
   - Treatment goals;
   - How the FST intends to accomplish the defined goals (TASKS); and
   - When the tasks will be performed and completed (TIME LIMITATIONS).

   Related Subject: Section 2, Chapter 5.5.6, Guide to a Family-Centered Services Assessment

10.3.1 Identification of the Presenting Problem(s)

The Children's Service Worker shall identify the presenting problem(s) (also known as symptom) which results from the dysfunction of the family's system. The presenting problem(s) (symptom) is usually the behavior which caused the child(ren) to be placed in out-of-home care. Typically, the presenting problem(s) is a superficial behavior that is symptomatic of underlying problems within the family system.

10.3.1.a Family's Perception of the Presenting Problem(s)

The Children's Service Worker shall allow all family members to identify and state their opinions about the presenting (and underlying) problem(s). Encouraging this ventilation of opinions signals respect of the family and the importance of their cooperation. The worker should observe who is being blamed for the family discord as well as the perception of the family of its relationship to outside systems.

The child(ren)'s view of the problem(s) should be obtained. The Children's Service Worker should use care in determining whether this information is best obtained during a private interview with the child(ren), in a joint interview with the parents, or both.

10.3.1.b Collateral and Other Information

The Children's Service Worker should include other pertinent information about the family, including information obtained from relevant collateral sources and other professionals involved with the family. Out-of-home care providers, school personnel, and treatment resources may provide valuable information regarding the child(ren). Closed and active FCS files may provide valuable historical information regarding the family, their past perceptions of problems, and their participation in past treatment activities.

It is necessary to check with these sources to verify information that is provided by the family. Information obtained from collaterals may contradict the family's account of the presenting problems. Inconsistencies may not be intentional lies by the family, but merely their understanding or version of reality and should be viewed as such. This comparison may provide insight into the accuracy of the family's perceptions, which are listed previously.

Use Form SS-6, Authorization for Release of Information, when necessary.

10.3.1.c Study of the Presenting Problem(s)

It is important for the Children's Service Worker to study the family's presenting problem(s). The presenting problem(s) is usually the behavior which brought the family to the attention of the Division and the child(ren) into out-of-home care. We need to look at what precipitated, or caused, the presenting problem(s).

Causality can be studied from a linear or circular perspective. The linear perspective tends to look only at what immediately preceded the presenting problem(s); at who or what caused it. This perspective tends

to affix blame in that the problem(s) is viewed as belonging to an individual or as someone's fault.

Viewing behavior from a circular perspective is conducive to a family-centered approach in that problems are viewed as belonging to the family system. A circular viewpoint looks at behavior as reciprocal interactions which have no identifying beginning or end. Behaviors and their precipitating conditions are reinforced within the system and this reinforcement leads to behavioral patterns.

Two techniques are presented to assist in this study:

- Time lines, which are used to identify "critical events" experienced by the family. By plotting these events on a linear line, this method can help determine the onset of the presenting problem(s), what was going on before and after the onset.

  Related Subject: Section 7, Chapter 25, Diagramming Families for Assessment.

- "Sequences of behavior" around the presenting problem(s); behavior that is diagrammed in a circular manner. This allows the Children's Service Worker and family to see how the presenting problem(s) is embedded in sequences of family behaviors. It can help gain insight into how these repetitious sequences may serve an underlying purpose for the family.

  Related Subject: Section 7, Chapter 25, Diagramming Families for Assessment.

10.3.1.d Function of the Presenting Problem(s) (Symptom)

The Children's Service Worker shall describe the possible function or purpose that the presenting problem, also known as the symptom serves within the family system.

The presenting problem or symptom is usually the behavior which brought the family to the attention of the Division and the child(ren) into out-of-home care. Typically, the presenting problem(s) is a superficial behavior that is symptomatic of underlying problems within the family system. (Understanding the function of the symptom is probably the hardest change to make in how we look at problems.)

From a systems point of view, an individual's symptom is a functional, protective, or adaptive response to a dysfunctional family situation. An individual's distress, for example, may function to restore family stability

by expressing and deflecting family tension (i.e., children develop delinquent behaviors in order to save the parents' marriage from failing; spouses develop symptoms in order to deepen the other's sense of inadequacy). This response may not be a conscious behavior with a conscious intent.

We need to ask ourselves what purpose a particular symptom serves, how does it help keep the family in balance (homeostasis), and what does it say about what is really going on in the family. We need to remember that behavior must be reinforced to continue. We need to ask ourselves how a particular behavior is reinforced within the system.

In this manner, the underlying issues, which led to the presenting problem(s), can be identified.

10.3.1.e What Needs to Change

By carefully studying all information obtained in the assessment process, the Children's Service Worker shall describe what he/she thinks are the underlying sources of the family's dysfunction.

Once the presenting problem(s) has been identified and its possible function is described, the Children's Service Worker should identify areas of family functioning that are most critical to resolving the presenting problem. In other words, to address the presenting problem, what needs to change within the family? What are the underlying situations that the family is reacting to by exhibiting the presenting problem?

10.3.1.f Behaviorally Specific Goals

To address the underlying sources of dysfunction, the family and Children's Service Worker must set behaviorally specific goals. These goals should focus upon the critical underlying sources of dysfunction and identify what the family will be doing differently when change occurs.

Goals may reflect direct and indirect interventions. Direct interventions address the presenting problem directly. They tend to reduce the immediate crisis and address the immediate safety issues. Indirect interventions address the behaviors and circumstances that may be contributing to the presenting problem. Indirect interventions can be identified by diagramming the sequence of behaviors or events and by determining the function of the presenting problem (symptom).

Use the family definition of the problem as much as possible. For example, if the mother states the problem as "My children don't respect me", then the Children's Service Worker's question becomes "How will we know when your children are showing some respect?"

The goals must be achievable. If the mother decides that her children will be showing proper respect if their rooms are clean everyday, the Children's Service Worker might want to help modify the goal by saying, "Most kids, even the most respectful ones, don't have their rooms clean everyday. What do you think would be reasonable to expect from your children? Twice a week, maybe?"

When possible, goals should identify increments of change so that the family and Children's Service Worker can see when change is beginning to occur. Using increments may not be possible with goals that directly address physical and sexual abuse, and other immediate safety issues. In these instances, incremental change may still put the child at risk as change must occur rapidly to ensure the child's safety. The necessary change to ensure the child's safety will be a direct goal that addresses the presenting problem and will be behaviorally specific.

Indirect goals, to address contributing and underlying factors, may be used in conjunction with the direct goal. Indirect goals may be written incrementally and will also be behaviorally specific.

Related Subject: Section 3, Chapter 4.7, Setting Behaviorally Specific Goals.

Understanding the underlying reasons that parents abuse/neglect their children provides a basis for the decision-making process in permanency planning. The following provides a theoretical framework of characteristics evidenced by parents and an array of services that may be offered to rectify the situation which led to placement of the child(ren) in out-of-home care. While this information may be utilized in formulating a treatment plan with the family, it should not be used as a "prescription" to "cure" the family. Further, consideration must be given to culture, values, beliefs and traditions of the family which may affect their ability and/or willingness to take action which may be deemed necessary for the child's protection.

10.3.2 Why Parents Physically Abuse

Over 25 theories have been developed to explain why physical child abuse occurs. Those that appear to provide the best explanation include factors at four levels:

1. Individual;
2. Family;
3. Community; and

4. Society.

At the individual level, the perpetrator's personality, lack of personal resources, personal stresses, and faulty cognitive processes may contribute to abuse.

Parents who are authoritarian, who have not had their own needs for nurturing met, who are impulsive, and who have some kind of mental illness or psychopathology, are more likely to physically abuse their child. Abuse is more likely to occur if parents lack self-esteem, have poor parenting skills, and poor coping abilities because these parents don't have the resources necessary to prevent the frustration which leads to abuse.

Personal stresses, which create high levels of frustration, include family conflicts, substance abuse, physical and mental illness of the parent or child, and disruptive child behavior or special features of the child that set him or her apart.

Perceiving the child as difficult, having unrealistic expectations or a negative attitude toward the child generally indicate some problems in the parent's thinking.

Family characteristics that may contribute to an abusive situation include marital problems, norms for punishment and family values.

In abusive families, marital conflicts may arise over economic problems, socialization of the children, or the sexual satisfaction of the marital partners.

Parents may view harsh discipline, including beatings, as appropriate punishment for a child's misbehavior.

Family values may include violence as a solution to problems.

Families may also engage in abusive behavior because community values and norms support a subculture of violence including the use of violence to discipline children. Communities may also increase social isolation.

In some communities violence is the accepted and expected way to solve problems. If parents and spouses don't use violence, they may be seen as ineffective.

Some communities are tightly organized making it difficult to fit in for newcomers or people who don't follow community norms. These families may become isolated and angry.

Social factors include the parent's age, gender, and socioeconomic status. Gil (1970) has related abuse to high levels of unemployment, overcrowding, poverty and other indicators of social and economic stress.

In our society men are expected to have more power and control in the family.

Families of lower socioeconomic status must compete with others for scarce resources, which leads to depression, frustration and abuse.

10.3.2.a Factors to Consider in Reunification Related to Physical Abuse

Physical Abuse

1. What type of abuse occurred?

2. How severe was the abuse?

3. How often did physical abuse occur?

4. Conditions in the household which exist at the time of the abuse, i.e., what was going on right before the child was hurt (If a caretaker has admitted to the abuse, what was happening just before they hit the child?). Who was the primary target of abuse? One child, all the children? Can the parent explain why one child was targeted?

5. What purpose did the abuse serve (parent's perception, i.e., discipline, outlet for anger, and/or frustration)? Was physical abuse a part of parent's parenting, i.e., was parent physically abused as a child?

6. Have any incidents of abuse occurred since intervention (during prolonged visits)?

7. What has been the visitation plan; what has occurred during visitation?

8. What treatment services has the parent received to alter past problem behavior? Has parent actively participated in treatment? Has parent benefited from treatment?

9. What is required of parent and other family members to prevent recurrence of abuse? State specific behaviors parent has learned (utilized/demonstrated) to replace past abusive behavior.

10. Who will parent call if past behavior recurs or if parent feels behavior could recur? Does parent/child know the indicators that behavior has/will recur and when to call?

11. Who will child tell if abusive behavior recurs in the household?

12. Is an aftercare plan written, and do all treatment team members have a copy of the plan?

10.3.2.b What Should be Done Before the Child Returns Home

Although each of the previously stated factors may contribute to abuse, the likelihood of abusive behavior recurring should be the primary basis for deciding whether or not the child should return home. This is often difficult to establish with any certainty. For this reason and because of the possible serious consequences to the child, any disposition of an abuse case (or serious abuse) should be a shared decision. Expert opinions from psychologists or psychiatrists can be helpful in determining potential for further abuse.

Related Subject: Chapter 10.1, of this section, Legal Basis. This explains Section 210.117 RSMo, regarding the reunification of children with parents who have a criminal history.

10.3.2.c Individual Factors

If parents have grown up in foster or group care, or in an abusive home, they may not have had their needs for nurturing met. Because they have not had positive role models for family life, they may not be able to parent. In these cases counseling is necessary, but parents may never be able to parent and termination should be considered if there is no change in the parent-child interaction within six (6) to nine (9) months.

In other cases, parents may not have had positive role models and are unable to parent, not because of underlying emotional problems, but because of lack of experience. For these parents, parenting classes may provide an understanding of how to respond positively to their child's needs.

For a parent facing personal stresses, learning problem-solving skills and how to access resources may relieve some of the pressures. The resources should match the existing problems and may include health care, therapy for a parent or child, family therapy, employment, counseling or housing. If parents lack job skills or need therapy to better understand how to solve problems, a child may return home before the parent(s) have completed training or therapy. There should be some indication of beginning change.

Other more difficult problems include the parent's abuse of substances or the parent's emotional illness. In these cases parents should receive treatment and their therapist must help determine if they are ready to parent. This is a situation in which shared decision-making is essential.

If the substance abuse or emotional illness is chronic and debilitating, termination should be considered.

If the child is suffering from a medical problem, the parents must access medical support necessary to treat the child. If the problems are severe and the parents are unable to understand the necessary medical treatment, termination should be considered.

When a parent has a chronic medical condition, the worker needs to determine, with the help of medical professional, if the parent will be able to care for the child. Can the parent care for the child with additional support? If so, that support, which may be a housekeeper or caregiver, should be obtained to enable the family to be reunited.

If a child is experiencing emotional problems, a range of support services may be needed to return the child home. These may include respite care, a person to accompany the child to school, special schooling, and therapy for the family and child. The Department of Mental Health should be involved and should provide services needed to maintain the child at home.

Sometimes there may be other factors that set a child apart from others in the family and cause the child to be the target for abuse. These may include a physical disability of some kind, the age of the child (some parents feel more comfortable with younger children, some with older children), the gender of the child, or the child's birth order. Parenting classes, Parents as Teachers, or therapy may help with these perceptions.

Closely related to the above is abuse caused because parents have unrealistic expectations of their child. Parenting classes may be appropriate. Or, if the child is young enough, Parents as Teachers is a resource. If the parent has a hard time seeing anything positive about their child or sees the child as stupid or unmanageable, it is likely that the parent is projecting these feelings onto the child. This is a more difficult problem to treat and usually calls for therapy. Until the parent understands the underlying cause of these beliefs, the child will be at high risk for emotional maltreatment and at risk for physical abuse. Because of these risks, the parent should have received therapy before the child returns home.

10.3.2.d Family Characteristics

If parents are involved in frequent marital conflicts, counseling is needed. Parents may continue to fight, but they must learn not to use the children as stand-ins for their partner. Parents' marital conflicts are not usually a sufficient reason to maintain children in out-of-home care unless these conflicts are violent.

Parents who believe it is their right to discipline children however they feel is best can be difficult to work with. These parents may learn other techniques in parenting classes and use those when disciplining children. These parents may revert to old discipline forms under stress. They should be followed closely after a child has returned home.

In the above case, parents use inappropriate methods when disciplining their children. In other cases, the family uses violence to solve problems. In these families, parents hit each other and the children, siblings physically attack other siblings, and neighbors are often threatened with violence. Until each family member learns anger management, it will be difficult to maintain children in the home. When the family learns better ways to deal with conflict, the child can go home. In a case like this, because family patterns of interaction must be changed, it is best to use family preservation before a child is removed or extended family preservation after a child is returned.

10.3.2.e Community Values and Norms

When families live in communities where violence is condoned, the family needs support to use other ways to solve problems. This is closely related to the above problem and the same resources can be used to bring about family change.

Families who are isolated from the community need to learn how to access resources and use people in the community for support. If they are unable to find support, they may need help in establishing resources or moving elsewhere.

10.3.2.f Social Factors

If families lack resources, i.e., employment, housing, food, they will often become frustrated and abuse their children. Parents may need job training and housing allowances before children are able to be returned. Housing should meet minimal standards, but should be safe for the family. Parents may not have jobs, but need an income that will meet minimal needs for housing, utilities, food, clothing, and medical care. When abuse is the result of this kind of frustration, it is usually easy to treat and the child can generally return home quickly if the child has been removed.

10.3.3 Why Parents Neglect

Because the terms abuse and neglect are often used together in much of the research done to understand why parents abuse and neglect their children, not

much has been written about neglect by itself. Polansky and his colleagues have done the most work in this area and their results are frequently used to explain the dynamics underlying neglect.

Polansky et al. (1981) takes a personalistic view of neglect. That is, neglectful behavior is seen as the result of a deficient parental personality. This is closely related to the viewpoint that sees neglect stemming from parental pathology, but it incorporates undesirable social conditions such as poverty and isolation as the stressful neglect-inducing factors (Tzeng et al., 1991). Essentially, this approach states that neglectful families are unlike others of the same status because they suffer from character disorders. These include the apathy-futility syndrome, the impulse ridden character, and infantile emotional functioning.

A variety of characteristics are evidenced in the apathy-futility syndrome:

- Parents, usually the mother, feel nothing is worth doing.
- Parents feel emotionally numb.
- Interpersonal relationships are superficial and lacking in pleasure.
- There is a lack of competence in many areas of living.
- Parents express anger through hostile compliance or passive-aggression.
- There is reluctance or refusal to make a commitment to positive stands.
- Parents exhibit "verbal inaccessibility" to others which results in a greatly reduced ability to problem solve because there is no internal dialogue.
- Parents demonstrate an ability to elicit the same feelings of hopelessness and futility in others.
- This last characteristic is one described frequently by protective services workers and others working with these families. They have an uncanny ability to make others feel worn out and as though there is no solution to the problems facing them. This is compounded by their passive-aggressive approach to problem solving. They will often agree to follow through on suggestions, but when the worker returns, have done nothing. They may have valid excuses, more often they just didn't get around to it.

Polansky also describes these individuals as being very concrete in their thinking, and as having psychosomatic illnesses. They are often unable to

evaluate their own actions and frequently have a distorted self-image. Because their lives don't seem worthwhile, they also believe their children are somewhat unimportant (Tzeng et al., 1991).

The typical at-risk mother may also be of limited intelligence, and have limited work experience. She often marries the first man who comes along and this man is unlikely to be able to care for her because he lacks educational and vocational skills. She is often egocentric and has little child-caring skills (Polansky et al., 1981).

Polansky has found that neglectful parents may also be impulse ridden. They are unable to delay gratification and have little concern for their children. They may leave for long periods of time, with only an older child in charge. Children with these parents are neglected because their parents act on their own wants first. In studies that have been done, as would be expected, impulsivity has been found to correlate negatively with the quality of child care.

Impulse-ridden parents are often involved in substance abuse and may leave their children unattended while they are obtaining or using alcohol and other drugs.

Neglectful parents are also characterized by infantilism. This is most often seen as immaturity, or lack of competence in approaching problems. These parents have little capacity for self-evaluation and believe problems are caused by external events. They are unable to recognize their role in difficulties and often are unable to follow through on tasks once started.

Polansky et al., (1981) suggest a cycle of neglect that starts with the parents' parents. The neglectful parents grow up in a situation where their parents were unable to adequately care for them, and they repeat the cycle with their own children.

Poverty and isolation also play a role in neglect (Tzeng et al., 1991). When parents do not have the material resources they need, they are more likely to give up and feel as though they are unable to care for their children. Social isolation increases the parents' feeling of hopelessness and lack of control over their situation. Without social support, they are more likely to feel unable to cope. When these parents are faced with normal stresses, they have no emotional, material, or social supports that will help them manage.

A final factor that must be evaluated in neglect cases is the parent-child interaction. Compared to abusive and controlling mothers, neglectful mothers have been found to rate their children as having more conduct problems. They also rated their children as more dysfunctional, and were characterized by their extreme negativity and low rates of positive interactions with their children. Of the three groups of parents, neglectful parents were the least compliant with their children's requests.

10.3.3.a Factors to Consider in Reunification Related to Neglect

Neglect

A. What type of neglect has occurred in the family, i.e., physical, emotional, etc.

B. How long had neglect occurred? Generational; stress induced; intermittent?

C. Have treatment services targeted the type of neglect which occurred, i.e., if poverty contributed to the neglect, have those conditions changed, and will the new stability continue to support reunification of the children?

D. How will child readjust to family if reunification means reduction in material standards? Has this been discussed with the child and the parent(s)?

E. What is required of the parent(s) and other family members to prevent the recurrence of the problem? Include specific behavior which must or must not occur.

F. What has been the visitation plan? What has occurred during visitation?

G. Who will parent or child call if help is needed to prevent recurrence of the neglect; will the parent/child know when to call?

H. Does parent know community support systems and how to access those services?

I. Is an aftercare plan written, and do all Family Support Team members have a copy of the plan?

10.3.3.b What Must Happen for the Child to Return Home

Neglectful parents are probably the most difficult to work with to bring about changes necessary to return a child home. There are usually a range of factors that contributed to the removal of the child including the condition of the home, the parent's inability to adequately supervise the child, and the personality disorder of the parent. While these are interrelated, changes must occur in each area before the child can return home.

Parents who exhibit characteristics of the apathy-futility syndrome can be very draining to work with, but those characteristics that make the parents

most difficult are the same that need to be changed. Without change in the parent's approach to problem solving and relationships, the neglect will reoccur.

Related Subject: Chapter 10.1, of this section, Legal Basis. This explains Section 210.117 RSMo, regarding the reunification of children with parents who have a criminal history.

10.3.3.c Substance Abuse or Mental Illness

If substance abuse or mental illness is contributing to the abuse or neglect, these should be assessed and treated first. The professionals involved with the treatment should be willing to indicate that the parent has made sufficient gains to be able to adequately supervise her child or children.

Because the following changes may take a long time, it is not reasonable to expect all of them to be accomplished before a child is returned home. Instead, there must be some indication that changes are beginning to occur.

10.3.3.d Reframing

Neglectful parents should learn to reframe situations and become less negativistic in their approach to life. They should also begin to develop some empathy for their child. This will improve parent-child interaction and will lessen the likelihood of the cycle of neglect being repeated.

10.3.3.e Living Situation

Parents should obtain housing that is safe and have adequate resources to provide food, clothing and medical care for their children. They should be able to demonstrate what is needed to maintain housing and to provide adequate nutrition for their children. They should also be able to provide the necessary medical care for their child. If a child has a serious medical condition, and the parents are limited intellectually, they may never be able to care for their child. This should be evaluated as soon as the child is placed in out-of-home care.

10.3.3.f Adequate Supervision

Apathetic-futile parents should learn to request help from family and friends. They should be able to evaluate situations, determine what is needed to protect their child and take the responsibility for providing that care or obtaining those services. They should be able to indicate those circumstances that require a baby sitter and use one when needed.

10.3.4 Why Parents Sexually Abuse Children

It has been suggested that sexual abuse occurs because of early, unresolved trauma; because cultural norms promote the transference of male sexuality into violence and sexual abuse; because of the erosion of sexual norms; or, as presented by Finkelhor, the existence of four (4) preconditions which, when met, lead to abuse.

Although Finkelhor's model does not explain all the reasons for sexual abuse to occur, it does present a helpful approach for understanding what changes must occur before a child can be returned home. When it is combined with a model developed by Faller (19), it provides even more guidance in understanding when reunification can occur.

Finkelhor's model has four (4) sequential preconditions that lead to sexual abuse:

1. The perpetrator is motivated to sexually abuse a child;

2. The perpetrator overcomes internal inhibitions against the motivation;

3. Perpetrator overcomes external inhibitors against the motivation; and

4. The perpetrator, or some other factor, overcomes the child's resistance (Tzeng et al., 1991). Faller has suggested additional features that will be integrated into Finkelhor's model.

Motivation to abuse includes a sexual arousal to children, sexual abuse or trauma when the perpetrator was a child, or cultural factors. In some communities and families, sexual abuse of a child is assumed to be the father's right.

A variety of factors may help the offender overcome internal inhibitions against acting on the motivation to abuse. A parent may use alcohol or substance abuse as a means to lower internal inhibitions. Other parents may have poor impulse control or may act impulsively. Parents may have errors in thinking. They may reason that abuse is okay because their daughter needs to know about sex and this is keeping it within the family. Some perpetrators have pervasive superego deficits; that is, they have little or no conscience and do not believe they are doing anything wrong. Finally, a few perpetrators begin perpetrating after they become senile.

Once the potential perpetrator has overcome internal inhibitions, they are faced with external impediments, which present obstacles to the abuse. If the non-perpetrating parent has low self-esteem or is not very assertive, they may be unable to protect the potential victim. If the child is left alone and unprotected, they may be more likely to be abused. When the non-perpetrating parent has

poor family management skills, she may not provide a safe environment for the child.

Even though the external impediments are overcome, abuse will occur only if the potential perpetrator overcomes or undermines the child's resistance to the abuse. He may offer bribes or special favors. He may threaten the child. The child may believe that adults must be obeyed and may be unable to resist the abuse. Additionally, parents may not support the child when the child first tries to report the abuse.

10.3.4.a Factors to Consider in Reunification Related to Sexual Abuse

Sexual Abuse/Incest

A. What type of sexual abuse occurred?

B. Who was the perpetrator?

C. Who in the family was abused? Any siblings?

D. Did family receive and participate in services specific to sexual abuse?

E. Was the criminal justice system involved with the family? Is prosecution process completed?

F. Who in the family will protect this child? Who would child tell if sexual abuse recurs?

G. What is required of parent(s) and other family members to prevent recurrence of the problem? Include specific behaviors which either must or must not occur. What has been the visitation plan; what has occurred during visitation?

H. Is an aftercare plan written and do all Family Support Team members have a copy of the plan?

10.3.4.b What Must Happen for the Child to Return Home

Before the child can return home, the perpetrator must no longer have access to the child. The child must be helped to resist the abuse and the external impediments to the abuse must be reinforced. The perpetrator must strengthen his internal inhibitions.

Work should begin on all levels. The perpetrator must engage in treatment to understand his cycle of arousal and how to use internal and external inhibitors to prevent child sexual abuse from occurring. The non-perpetrating parent must decide to support the child. She and the child must be in therapy. In treatment the non-perpetrating parent must learn how to advocate for the child and to make changes in the family to protect the child from abuse. The child must learn that she has control over what happens to her and that she can resist the perpetrator if he is still in the home. The child must be supported by the non-perpetrating parent and by the therapist.

The child can return home when family members are able to provide the external impediments necessary to prevent the abuse from occurring again. These may include removal of the perpetrator.

Related Subject: Chapter 10.1, of this section, Legal Basis. This explains Section 210.117 RSMo, regarding the reunification of children with parents who have a criminal history.

10.4 Development of the Family Treatment Plan for Reunification

The language in the plan shall be clear and understandable to the family. Expectations must be written in simple, behaviorally specific and descriptive terms.

The plan shall be written in a clear, legible manner. If the case manager, parents, child, and placement resource are not located in the same county or state, the family Children's Service Worker will be responsible for sending the portion of the Family Treatment Plan completed in the service county to the case manager county. The case manager will send a complete copy of the family treatment plan to each participant. The plan should be typed, if possible, to add a more professional appearance.

Below are five (5) steps that are important in developing an effective treatment plan with the family:

1. The Children's Service Worker shall actively involve the family in the planning process. As in the family assessment process, the treatment plan is developed with the family, not for them.

   Family involvement serves to:

   - Facilitate the development of a therapeutic alliance between the Team members. It provides evidence that the family's feelings and concerns have been heard and considered;

- Promote the family's investment in the reunification process. People who are involved are more likely to change;
- Empower parents to take the necessary actions to change dysfunctional behavior patterns;
- Help ensure that all Team members are working toward the same end; and
- Initially, the members of the Team may have differing perspectives on the reasons for the Division's intervention, which resulted in the child's placement in out-of-home care. This obstacle can be overcome through reframing behaviors, emphasizing strengths and giving Team members an equal voice in identifying problems and solutions.

2. The Team shall identify reasonable and achievable goals and tasks that address identified risk factors. Important points to consider when selecting goals and tasks are:
   - Goals and tasks should be behaviorally stated so the Team knows when change has occurred;
   - Goals and tasks should be phrased in a positive manner. They should specify what change needs to take place, not what should be stopped;
   - Goals and tasks should be phrased in a clear and understandable language;
   - Tasks should be very specific. All Team members should know exactly what has to be done within the specified time frame;
   - Initial tasks should be meaningful to the person or family. They should be achievable in a two (2) to four (4) week period. These tasks should be viewed as a need and priority by the family member(s).
3. The Team shall address the relevant needs and risk factors identified in the assessment. The family's strengths and resources are to be considered when determining the tasks needed to achieve treatment goals. The Team should:
   - Consider the environmental and other influences upon the family. Start where the family members are and help them select goals which can realistically be achieved in the time frame;

- Recognize and reinforce family efforts. Acknowledge their achievements.

NOTE: It should be understood that any significant change in the family's circumstances (i.e., change in household composition) which could increase the risk of abuse/neglect to children would affect the treatment plan.

The Children's Service Worker shall be able to document what all participants in the plan will do and when. Therefore, the plan should:

- Describe what family members, the family Children's Service Worker, placement provider and any other service providers will do;

- Identify time frames for accomplishing each task and the overall treatment goals. Treatment plans must not exceed 90 days.

4. The Team shall decide how achievements and goal attainment will be measured.

5. The Team will review the plan every 30 days, or more frequently, if necessary, to evaluate progress and the need for plan revision.

10.4.1 Reunification Goals

- Reunification goals state what the Team intends to accomplish during the treatment process.

- Establishing sound treatment goals requires the Team to have a common understanding of what needs to be accomplished to facilitate reunification. These goals must be relevant to the issues which resulted in the child being placed in out-of-home care, as identified in the family assessment.

- Usually, the family assessment will indicate several critical areas, or underlying problems, for casework intervention. Focusing upon the underlying problems requires the Team to establish *desired outcomes*, which will improve family functioning allowing the child to return home. The *desired outcome(s)* for the casework intervention is the reunification goal. The treatment goals are written on the family treatment plan and serve as a "road map" for the Division's intervention into the family.

- Achievement of the goals should resolve or decrease family problems, which resulted in out-of-home placement and should reduce risk to the children. When risk is reduced and/or eliminated, families should be reunited.

- The Team should limit the number of goals on the treatment plan so that the family will not be overwhelmed. Generally, two (2) goals written on the treatment plan are sufficient at any one time. This allows the family to focus upon one or two critical issues, build upon success and move on. It is important for the family to fully understand the rationale for limiting the number of goals on the treatment plan.

- It is important that the Team clearly identify goals and tasks that cannot, or should not, be pursued at this time. The Team should explain that there may be other identified goals if it appears that more than one treatment period will be necessary. This should help prevent the family from thinking they have accomplished all their goals, only to find they have more sprung on them at a later time.

10.4.1.a FST's For Families Reaching TANF Lifetime Limit

For families reaching their sixty (60) month lifetime limit for Temporary Assistance, the format of the plan should include the goal of achieving self-sufficiency. A self-sufficiency component should be addressed in a FST at least six months prior to a family reaching their lifetime limit and in every subsequent FST, until the issue is resolved. The Children's Service Worker will be responsible for contacting the IM worker to begin the planning process for the FST. After sharing pertinent assessment information, the CS and IM worker will jointly determine how to prepare the family for the team meeting, work with the family to set up the meeting, and provide the necessary support and follow up.

NOTE: In the past, certain responsibilities, i.e., parent/child visits, sharing information with the agency, providing financial support, for some reason may have appeared as goals/tasks on a treatment plan. This should only occur if there is a specific behavior that the parent must exhibit in conjunction with this responsibility. (Mrs. Jones will be sober when she visits Paula at the Smith home on Tuesdays at 3:00). Otherwise, the Team should discuss that these responsibilities must be met throughout the child's stay in out-of-home care and the notation can be made under "Additional Information."

- By establishing goals directly related to an underlying problem and selecting the easiest goals first, the Team can facilitate successful planning.

The specific goals should be:

- Clearly phrased in a concise and understandable manner for all Team members.

- Written in behaviorally specific terms and identify what the family will be doing differently when change occurs. Goals should not be defined as services.

- For instance, rather than having a goal identified as "Mrs. Jones will attend parenting classes," the goal should focus on what needs to be achieved by her attendance at parenting classes.

- Measurable and time-limited. Behaviors which can be measured by frequency within certain time frames will better enable the Team to evaluate progress;

- Realistically obtainable and should recognize minimally acceptable expectations and standards; and

- Mutually agreed upon by the Team. The Children's Service Worker's skills must be utilized to set goals with the family and not for them.

- The time frames for the number of the goals may vary. Short-term goals will be more easily and quickly obtainable. They provide the family some measure of success within a brief period of time. Long-term goals will require a longer period of time. Generally, they are more difficult and will require more consistent effort on the part of the family. Subsequent treatment periods which build upon previous successes may be required for accomplishment of long-term goals. Accomplishing long-term goals should result in the family's achievement of a minimal level of functioning and the reunification of the family.

10.4.2 Tasks

To achieve a treatment goal(s), the FST must identify tasks that, when completed, will achieve the specific goal(s). Tasks can be specified for the family unit, an individual, Children's Service Worker, placement provider, or other provider or resource. The FST must limit the number of tasks so as not to overwhelm the family.

Tasks of other FST members should complement the family's tasks. They should encourage family empowerment and enhance the family's ability to solve problems. To ensure success, family tasks should take into account the following:

- The cognitive and social abilities of the family members

- The family's level of cooperation and motivation;

- The family's ability and willingness to use community resources; and

- Practical limitations, such as transportation, employment and other responsibilities.

10.4.3 Examples of a Goal and Task

Goal

Ms. Anderson will achieve and maintain a clean, rodent-free home by 6/20/01.

Tasks

Ms. Anderson will purchase five mouse traps and set them behind furniture in each room of the house by 5/4/01.

Ms. Anderson will check the traps for mice, dispose of the dead mice and reset the traps daily.

Ms. Anderson will put all food in containers with lids and store them in cabinets or the refrigerator. This includes all food currently in the kitchen, newly purchased foods and food left over from meals.

Ms. Anderson will wash dishes, pots and pans, wipe off the stove and counter, and sweep the kitchen floor every day by 7:00 p.m.

Goal

Mrs. Davis will develop a one month schedule of activities for herself and her children and explain to her Children's Service Worker how she will supervise the children during that time period. This schedule and discussion will occur by 8/4/01.

Tasks

Mrs. Davis will participate in parenting classes held Tuesday and Thursday at the Goodplace Center from 2:30-3:30 p.m. from 5/23/01 through 8/2/01. Mrs. Davis will get the list of approved babysitters from the Westend Elementary School by 6/13/01. She will interview and select two babysitters that she will use to care for her children by 7/16/01.

10.5 Time Limits

Time limits are needed to:

- Evaluate the success of the specific tasks;
- Help the FST measure progress on an ongoing basis;

- Prevent the family from being overwhelmed; and

- Ensure permanency for the child as soon as possible. Measuring progress in increments makes goal attainment more manageable.

It is important not to mislead the family when discussing the time limits of the treatment plan.

The FST should discuss that, depending on case progress, successive treatment plans may be necessary if problems reoccur.

The maximum length of a family treatment plan is 90 days from the date it is signed by the family members. Treatment goals that are identified in the plan are expected to be achieved in this period.

During the 30-day agreement period, the Children's Service Worker and family shall complete the initial assessment and treatment plan. If unresolved treatment issues exist after the plan's expiration, the team must decide, based on assessed risk, if the plan should be renewed for another 90 days, or recommend reunification or some other permanent plan. A new assessment and treatment plan is due within 30 days of the plan's expiration.

10.6 Family Approval

The reunification plan is to reflect a cooperative agreement between the FST members, therefore, all parties present should sign the plan. Children age 13 and above shall sign the plan.

This process should be as informal as possible. The family's approval of the plan should convey their agreement to the goals and tasks of the plan. Family refusal to sign the plan may not indicate their refusal to participate in reunification services. A copy of the plan shall be provided to the members of the FST. If the family refuses to participate in the planning process, the remaining FST members shall decide the appropriate action to take.

10.7 Services/Resources

During the treatment planning process, the FST will identify specific resources to assist the family in accomplishing certain tasks and achieving stated goals. The FST should carefully consider the family's capacity to benefit from the resource and the capacity of the resource to meet the needs of the family. Example: A parent with limited reading and social skills and poor parenting skills would benefit more from Parents as Teachers than formalized parenting classes. Also, the Team should not overlook resources, which can be provided by other agencies, community organizations and natural helpers (family friends and kin).

10.8 Case Plan Implementation

The Children's Service Worker is responsible for coordinating the implementation of the treatment plan. These responsibilities include:

- Offering the family support and encouragement to follow through on the treatment plan.

  Generally, families need support most in the time of crisis. As the work progresses and the family gains more control in more areas of their life, the need for support diminishes. The family should be allowed to take more responsibility and initiative and be encouraged for their resourcefulness.

  If a family is not following through on the treatment plan, the Children's Service Worker will determine what is occurring. Do not assume the family is resistive. Once the reason is determined, i.e., fear, conflicting schedules/responsibilities, inability to access resource, the Children's Service Worker and the family will (or should) adapt the case plan or provide additional support and encouragement as needed.

- Regular contacts with service providers to assess family's progress toward goal achievement.

10.9 Case Plan Review

Generally, the FST will meet at 30 day intervals to review the treatment plan. The purpose of the review of the treatment plan is to:

- Gather updated information from the family to determine:
  - Previously identified needs that have been met,
  - Needs remaining unmet; and,
  - New needs that have arisen and been identified.
- Revise the permanent plan, treatment goals, and strategies to meet needs identified during the case reassessment.
- Revise time frames to accommodate new strategies.
- Assess provision and use of resources:
  - Are the resources still relevant to the plan, goal and strategies?
  - Are the services being provided and used as scheduled? Does the schedule need adjusting?

- Are the services still appropriate?
- Have the resources/services been made accessible to the family?
- Have family members used the services? If not, why not?
- Are new resources/services needed?

- Assess the treatment planning process itself:
  - Is everyone involved who should participate?
  - Are all persons actually participating in the treatment plan review? Is that participation meaningful?
  - How are persons communicating and cooperating?
  - Has everyone's opinion about progress been sought? Has everyone been heard?
- Determine whether or not the case should be closed.

The treatment plan is tied to the original reason for agency intervention. When that reason has been resolved, agency intervention should cease.

Related Subject: Chapter 9, of this section, Permanent Outcomes for Children.

10.10 Recommending Reunification

Whenever possible, the goal of out-of-home care will be a timely family reunification.

Related Subject: Chapter 10.1, of this section, Legal Basis. This explains Section 210.117 RSMo, regarding the reunification of children with parents who have a criminal history.

Family reunification is one of several permanency planning goals that may be recommended by the FST for children in out-of-home care. Once family reunification is identified as the permanency goal, a reunification plan for the child shall be developed. This reunification plan shall include an aftercare plan, which describes the child's health care, and specific services that will be provided to the family once reunification occurs. As soon as the family has met the treatment goals and the Family Support Team determines that:

- The family can meet the minimal physical and emotional needs of the child with, supportive services if needed; and

- Needed supportive services are available and the family will utilize such services (family reunification may be recommended).

The Children's Service Worker will notify the family court, in writing, of the FST's recommendation to reunify the family.

The family court must respond with a court order authorizing the change in custody prior to any change in placement occurring. A formal hearing may or may not occur. Custodial arrangements and Children's Division's responsibilities will vary with each court order. The order for family reunification usually will be for one of the following:

- Court continues jurisdiction with physical custody granted to the parent and with legal custody retained by the Children's Division.

- Court continues jurisdiction with legal custody granted to the parent(s) and with the Children's Division ordered to provide supervision.

- Court grants legal custody to the parent and terminates jurisdiction.

10.10.1 Family Reunion Services

Following the return of the child the Division shall provide services to the family to facilitate successful reunification and monitor the care the child receives. Aftercare services should be offered to the family, if needed, when the court terminates jurisdiction immediately. However, acceptance of services is voluntary on the part of the family.

Through family reunion, with its intensive services, it is possible to recommend that a child be returned home. Families that can participate in the project must meet the following criteria:

- Goal is to return child(ren) to family AND this is not possible in the next six (6) months without extensive services;

- Safety issues preventing the child(ren)'s return have been identified;

- Family court agrees to return the child(ren) if family reunion is involved;

- Parent(s) and child(ren) are willing to participate in the project;

- The family has not been involved with Intensive In-Home Services in the past six (6) months.

If the FST and/or family Children's Service Worker and supervisor agree that the family qualifies for, and could successfully reunify if services are provided, the referral form (FR-100) should be completed. The referral form should be given to the family reunion coordinator who will present it to the pre-screening panel for review. The pre-screening panel (Children's Division, Legal Aid, CASA and Juvenile Court/Family Court (JCFC)

Legal Unit) will review the referral form and accept or reject the referral. If the referral is accepted, the case will be given to the family reunion specialist and Children's Division worker for a complete screening. Once it is clear that the family will benefit from the services and the enrollment criteria has been met, the case will be referred to the family court where their legal unit will initiate action with the commissioner involved. The family reunion coordinator requests the detention hearing returning the children to the family. The hearing will be held within two (2) weeks. A review hearing will be scheduled approximately 90 days from the detention hearing. A second review hearing will be held 60-90 days from the first review hearing to determine if the family can be released from jurisdiction.

The Children's Service Worker is responsible for ensuring a smooth transition for everyone involved. Although the family reunion specialist will be the primary person working with the family, the worker should meet the family reunion specialist and the family weekly and attend all staffings. Staffings are generally held every two (2) weeks.

10.11 Steps Taken in the Process of Returning the Child

10.11.1 Assess Parents Progress

Assess parents' progress in resolving the initial problem necessitating placement and identify with the parents a tentative return date.

NOTE: Child Welfare Housing Assistance should be considered if the child remains in out-of-home placement primarily because his/her family is homeless or living in inadequate housing.

NOTE: Parents/caretakers who are or may be eligible for temporary assistance should be evaluated for the Families Together program.

Related Subject: Chapter 1, of this section, Attachment B, Child Welfare Housing Assistance; and Chapter 6, of this section, Attachment D, Families Together Program.

10.11.2 Prepare Summary of Recommendation for Court

Prepare summary for court and request custody be returned to the parent, unless special circumstances exist (i.e., ICPC cases, the court has previously indicated an expectation that CD retain custody, trial visitations if the child has been out of the home for a relatively long period of time).

NOTE: No child shall be returned to his/her parents for the purpose of a permanent placement without first informing the court of the placement and assuring that the court order allows such a placement.

10.11.3 Development and Implementation of Aftercare Plan

The Children's Service Worker and the FST shall develop a time-limited aftercare plan with the parent and child (if appropriate) which outlines the continued responsibilities of the Division, parent, and child in order to ensure successful reunification. The worker shall continue to provide any specialized treatment services needed to maintain family stability and prevent recurrence of the behaviors,- which resulted in the original placement. Aftercare services may continue for up to six (6) months, subject to continuing court jurisdiction, and depending on the needs of the family, which are continually assessed by the worker and Family Support Team.

If the birth parent(s) or legal guardian resides out of state and the case plan is to reunite the family, interstate compact procedures shall be followed. For example, the receiving state will be requested to evaluate the home of the parent(s) and approve or disapprove the pending placement.

The receiving state should agree to monitor the placement. The sending state will retain legal custody until the receiving state recommends that custody be returned to the parent(s) or legal guardian.

10.11.4 Preparing the Birth Parent(s)

In preparation for the child's return, the Children's Service Worker and parent should discuss anticipated issues and develop plans for coping with those issues. These issues include, but are not necessarily limited to:

- Change in parent's lifestyle, particularly if they have not had any child care responsibility.
- How current family relationships might be affected.
- Child's behavior, i.e., feelings of separation and loss from placement provider, testing rules and limits.
- Child may compare parents to placement provider.
- Child must adjust to new community and school.
- Child may feel insecure and be "clingy" due to fear of another separation from parents.
- Parents may have periods of uncertainty about their ability to adequately meet the child's needs.

As the time for the child's return nears, visits between parent(s) and child should be more frequent and of longer duration, i.e., overnight, weekends, etc. Also, the parent(s) will likely need additional support during this time. The Children's

Service Worker should meet with the parent(s) at least once per week during this transition phase.

Prior to the child's actual return to the home, the Children's Service Worker shall provide the parent(s) and child with a reunification packet which must contain:

- The original birth certificate (one copy must be retained in the case record);
- The original social security card (one copy must be retained in the record);
- Copies of medical records or medical log, including immunization record and names and addresses of primary medical practitioners. This summary shall emphasize special medical needs of the child and appropriate treatment;
- A copy of report cards, transcript or grade records and the most current IEP;
- Written information or brochures on helpful resources (i.e., food stamps, housing authority, energy assistance). The Children's Service Worker shall assist the family in accessing these services in the community;
- Written summary of out-of-home placements and his/her growth, behaviors, and experiences during that time;
- Pictures of the child contained in the case record;
- Personal records (i.e., baptism record);
- Information regarding the child's KIDS account. The Children's Service Worker shall assist the family in the payee application process if the child has been receiving SSA (OASDI) or SSI benefits; and
- Life book.

In addition to the continued responsibilities of the agency, parent and child, the aftercare plan shall address the specific needs of the family and child, i.e., daycare, medical care, counseling, parent aide services and other supportive services.

Title XIX (Medicaid) may be left open for a maximum of 180 days after the child has been placed in the parent's physical custody when CD retains legal custody. The Medicaid card will be sent to the placement provider. Therefore, the

Children's Service Worker will need to ensure that the parent receives the card to use for the child. If applicable, the worker shall encourage the parent to apply for AFDC or medical insurance benefits for the child during the trial visit.

10.11.5 Preparing the Child

When the recommendation of the FST is return of the child to the birth parent(s), steps should be taken to prepare the child for this move. The amount and kind of preparation necessary will vary according to the child's age, length of time in out-of-home care and relationship with the birth parent(s) and placement provider. The placement provider shall be involved in, and aware of, the plans to return the child to the birth parent(s). The placement provider will need to take appropriate steps to prepare the child for separation. The positive attitude of the placement provider toward the return of the child to the birth parent(s) will influence the child's view of return.

The following steps should be taken by the Children's Service Worker, placement provider and parent in preparing the child for reunification with his family:

- Privately discuss with the child their feelings regarding reunification with the parent. Address fears, anxiety, expectations, responsibilities and safeguards that ensure the child's safety. The Children's Service Worker should recognize that the child may feel more comfortable discussing reunification issues with the current placement provider. Conversely, the child may experience feelings of disloyalty to the placement provider for wanting to return home. Also, the child may experience feelings of disloyalty to parents demonstrated by new acting out behavior.

- Visits with the parent(s) should become more frequent and longer in duration with increasing child care responsibility given to parent.

- Provide opportunity for the parent, child, placement provider, and Children's Service Worker to identify and resolve problems which occur during visits.

- The placement provider shall assist the child in making the transition to the birth family.

- The Children's Service Worker and the placement provider should review the child's life book with the child and biological parent during the transition phase of reunification.

10.11.6 Preparing the Placement Provider

As a member of the FST, the placement provider participates in making significant decisions in the child's life. Also, the placement provider will assume

an active role as mentor and helper to the parent to facilitate a successful family reunion. The goal of reunification should not come as a surprise to the placement provider. However, the bonds that develop between some placement providers and children are so significant that both the child and the adult may grieve the loss. Therefore, it is important that the Children's Service Worker recognizes the signs of grieving and assists the child and placement provider through this difficult transition.

Related Subject: Section 7, Chapter 7, Separation and Loss.

The Children's Service Worker and placement provider should also discuss:

- Placement provider's fears or anxieties regarding the child's return to parents.
- Anticipated changes in child's behavior during the transition phase.
- Placement provider's role in helping/supporting the parent and child make the transition.
- Updating life book and other records maintained by placement provider.
- Continued contact, if any, with child and parent.

10.11.7 Preparing the Non-Custodial Parent

In preparing the non-custodial parent for reunification with the child, the Children's Service Worker should consider the non-custodial parent's awareness and involvement in the child's placement, i.e., communication and visitation and his/her previous role in the child's life. In addition, the worker and non-custodial parent should discuss anticipated issues and methods for coping with those issues. Refer to previous section in this chapter concerning "Preparing the Parents." If necessary, an aftercare plan may be developed with the non-custodial parent to ensure successful reunification.

NOTE: If the family/juvenile court terminates jurisdiction, legal custody will revert to the prior legal custodian. Non-custodial parent must obtain legal custody through civil court.

10.11.8 Develop Visitation Schedule

Develop worker/family visitation schedule, in order to aid both child and birth parents in the process of reintegrating the family. A parental trial visit may last up to 180 days prior to the court relieving the Division of custody. Refer to the SS-61 instructions for system instructions. This must be clearly documented in the treatment plan.

NOTE: Except for the Families Together program, Title XIX should not be closed until the child has been placed with the parent(s). Since the SS-61 still reflects the child's current out-of-home placement, the Medicaid card will be sent to the address of the out-of-home care provider. The CSW shall assure that the Medicaid card is given to the parent(s) for use for the child. If the parent/caretaker is approved for temporary assistance for the child during the trial visit, the Title XIX should be closed in ACTS in order for the child to receive Title XIX through temporary assistance.

10.11.9 Post-Reunification Support

Support services are critical to a successful family reunion. Reciprocal and open communication between the Children's Service Worker, parent, child, and placement provider is essential to identifying services needed for successful family reunification. Services should be consistent with the individual needs of family members. The following represents the minimum expectations for worker contact with the family:

- Visit with family and child once a week for the first month of reunion;
- Visit a minimum of once a month thereafter until the court terminates jurisdiction;
- Identify community supports needed to aid family reintegration;
- Continue any specialized treatment services needed to maintain the family stability and prevent reoccurrence of the behaviors which resulted in the original placement;
- Continue any needed referrals and assistance to the parent(s) for accessing primary and preventative health care, including prenatal care, well-baby, and post-natal care, and child spacing services;
- Contact by telephone, as needed;
- Determine that family demonstrates adequate care of children and termination of services can be considered;
- Determine with parents a projected date for case closing; and
- Closure visit after the court terminates jurisdiction.

Issues that the Children's Service Worker should discuss with the family and child during contacts should include, but are not necessarily limited to, the following:

- The progressive periods of child's adjustment, i.e., separation and grief, honeymoon, testing of limits, etc.;
- Parent's uncertainty about their ability to adequately meet the child's needs;
- Increased responsibility for meeting child's needs for safety and security;
- How family relationships have been affected by the child's return home; and
- What services have been helpful and what additional services are needed.

10.11.10 Requesting Termination of Court Jurisdiction

The Children's Service Worker shall request, in writing, termination of court jurisdiction according to the requirements of the presiding court.

10.11.11 Termination of Aftercare

Termination of aftercare services shall be a planned and natural component of the casework process. Due to its importance in the provision of services, the Children's Service Worker should prepare carefully for this process. Skills in terminating the helping relationship are just as important as skills that are used in establishing the relationship. The following are important factors to consider when recommending termination of aftercare services. However, this list is not all encompassing and the FST should consider the circumstances of each family.

- The family has stabilized and the risk of abuse/neglect to the child is minimal.
  - The client is engaging in those behaviors which were defined as desirable in the original or modified treatment plan.
  - Evidence exists that the family has methods that support the capacity to cope adequately with life stresses, problems, and complexities without producing harm to the child(ren).
  - The parent is capable of establishing warm, give and take, relationships with others and expresses recognition for the individuality of the family members.
  - The parent can tolerate frustration and other discomfort such as anxiety, guilt, anger, or grief.

- The parent can use his energies to concentrate on meeting needs of the children and others.

- The reasons for needed services no longer exist.

- Consultation with service providers used in the treatment plan supports the client's progress or improved degree of well-being and safety of the children.

- The family has demonstrated an awareness of available community support services, i.e., counseling, and the ability to utilize these services as necessary.

- Closure has been discussed with the family and they are aware of the plan.

- The family has optimally benefited from services and is not likely to demonstrate further progress given additional services.

- Court jurisdiction has been terminated.

10.11.12 Procedures for Closing a Case

The following procedures are required by the Children's Service Worker after the FST has determined that aftercare services should be terminated and the court has terminated jurisdiction:

- The Children's Service Worker shall close the necessary forms which include all SEAS forms, the SS-61 and SS-63, and the KIDS account.

- The Children's Service Worker shall send a letter to the family reminding them of the agreed upon date of closing and offer services if needed by the family in the future.

- The Children's Service Worker shall ensure that the court order terminating jurisdiction is in the file.

- Complete final page of CS-16.

Sources: The Risk Assessment was adapted from the Utah Child Protective Services Risk Assessment Project, Utah Department of Social Services, and the Utah Child Welfare Training Project, Graduate School of Social Work, University of Utah; 1987.

The Risk Assessment was adapted from Understanding Families, written by Jo Ann Allen, with contributions by Eloise Cornelius and Consuelo Lopez, and edited by Kittsu Swanson. It was developed under Contract #105-79-1107 for the Children's Bureau,

Administration for Children, Youth and Families, Office of Human Development Services, United States Department of Health and Human Services.

Technical Assistance in the development of the Family Assessment and Treatment Plan, its explanation, and instructions was provided by the National Resource Center on Family-Based Services, University of Iowa School of Social Work, Iowa City, Iowa.

MEMORANDA HISTORY: CS03-32; CD04-79